TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Texas Spine Joint

**Respondent Name**
Texas Mutual Insurance Co

**MFDR Tracking Number**
M4-16-3880-01

**Carrier's Austin Representative**
Box Number 54

**MFDR Date Received**
August 30, 2016

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "While the authorization provided by Texas Mutual does have the date range of applying from July 31, 2015 through August 31, 2015, the Hospital provided the exact procedure which was authorized."

**Amount in Dispute:** $5,721.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The requester provided imaging services on the date above. The preauthorization for those services states the date range is 7/31/15 – 8/31/15. Because the imaging study was performed 9/2/15, outside the preauthorized date range, Texas Mutual denied payment per Rule 134.600(p)(8)(A)."

**Response Submitted by:** Texas Mutual

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| September 2, 2015 | 72148 | $5,721.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/notification absent

- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 138 – Appeal procedures not followed or time limits not met
- 879 – Rule 133.250(B) – Health care provider shall submit the request for re-consideration no later than 10 months from the date of service
- 930 – Pre-authorization required, reimbursement denied.

**Issues**

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

**Findings**

1. The requester seeks reimbursement in the amount of $5,721.00 for outpatient hospital services rendered on September 2, 2015.

   The insurance carrier denied disputed service code 72148 – "MRI lumbar spine w/o dye" with claim adjustment reason code 197 - "Precertification/authorization/notification absent."

   The denial codes 138 – "Appeal procedures not followed or time limits not met" and 879 – "Rule 133.250(B) – Health care provider shall submit the request for re-consideration no later than 10 months from the date of service" were not part of the response from the carrier and therefore will not be considered in this review.

   28 Texas Administrative Code §134.600(p)(8)(A) states in pertinent part,

   > Non-emergency health care requiring preauthorization includes:
   >
   > unless otherwise specified in this subsection, a repeat individual diagnostic study:
   >
   > (A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline;

   The medical fee rate is calculated as follows:

| Procedure Code | APC | Status Indicator | Payment Rate | 60% labor related | 2015 Wage Index Adjustment for provider 0.8431 | 40% non-labor related | Payment | Maximum allowable reimbursement |
|---|---|---|---|---|---|---|---|---|
| 72148 | 0336 | Q3 | $286.41 | $286.41 x 60% = $171.85 | $171.85 x 0.8431 = $144.89 | $286.41 x 40% = $114.56 | $144.89 + $144.56 = $259.45 | $259.45 x 200% = $518.90 |
| | | | | | | | Total | $518.90 |

   Based on the above, the repeat diagnostic study has a reimbursement rate greater than $350 and therefore preauthorization was required. The Division finds the carrier's denial is supported.

2. The Division reviewed the "utilization review decision" and found the service in dispute was authorized between 7/31/15-8/31/15.

   Insufficient evidence was found to support a revised or extended authorization for the service performed on September 2, 2015. Therefore, no additional payment can be recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

| | | |
|---|---|---|
| | | October 18, 2016 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.